country, statistics illustrated significant differences. The number of new cases reported was fluctuating in Guinea and decreasing in Liberia, while the western part of Sierra Leone was experiencing the highest incidence of transmission. Although the weekly numbers remained similar, the disease was now more widely dispersed, creating challenges for the response.

Because of cross-border outbreaks in Mali, its Government requested that UNMEER establish an office in Bamako that became operational on 26 November. While the first case of Ebola had not resulted in a chain of transmission, a second case had resulted in six additional cases. Of the eight cases recorded in Mali, six resulted in death, including that of two health-care workers. Completing the 21-day surveillance period that began on 15 December, no further cases had been recorded, demonstrating the success of the Government’s efforts to strengthen preparedness in Mali.

Within the reporting period, of the 678 health-care workers who had become infected, 380 had died. Data collection and epidemiological data were still impacted by the inaccessibility of remote areas, unreliable reporting and underreporting by resistant communities. UNMEER was working with international partners and NGOS to address data collection and develop a unified, technology-based reporting system. The operational framework established at a multi-stakeholder conference convened by UNMEER in October resulted in significant progress. The collective efforts of national Governments, affected communities, and the UN system and its partners had resulted in reducing the spread of Ebola through establishing treatment centres and burial teams, and training thousands of contract tracers and social mobilizers in affected countries, which helped communities change their behaviour and traditional practices to prevent transmission.

With 221 trained burial teams, over 90 per cent of individuals reported to have died from Ebola received a safe and dignified burial. In some regions, portions of the population were still carrying out clandestine, unsafe burials, including the washing of the body before the safe burial team was called. Improved geographical coverage and greater mobility of safe burial teams were needed. By the 60-day mark, 70 per cent of people with Ebola in Guinea and Liberia had been isolated and treated. Ebola treatment units and community care centres were reinforced by community-based initiatives.

In Sierra Leone, at the 60-day mark, the target of isolating and treating 70 per cent of people infected with the virus was not reached in four districts, in part due to the shortage of adequate treatment facilities. The Government and UNMEER initiated the “Western Area surge” plan which intensified efforts to curb the disease in that region. The Mission mobilized operational partners to meet critical gaps, such as beds and convalescent centres, and help transport additional laboratories from within the region, airlift blood samples and deploy laboratory data specialists.

All three affected countries had the net capacity to reach the 90-day objective of isolating 100 per cent of all Ebola patients and ensuring safe and dignified burials in 100 per cent of Ebola-related deaths. Because capacity was not uniform across the districts and regions of each country, discrepancies were addressed by increasing laboratories, opening treatment units, increasing bed capacity and continuing safe burials. More than 100,000 teachers, religious leaders, traditional chiefs and community watch committee members received Ebola training in the three countries. In Liberia and Sierra Leone, the percentage of districts where safe burial was promoted by religious and community leaders had reached 100 per cent. Still needed were trained and experienced international medical responders with the requisite language skills to support national personnel. To respond to the increasing geographical dispersion of the outbreak, a large number of basic and more flexible deployable treatment and surveillance capabilities at the district level were needed as well.

As at 31 December, the Ebola Response Multi-Partner Trust Fund had pledges and deposits totalling $141 million, with $105.5 million disbursed to address critical unfunded gaps in the three most affected countries. Amounts committed still fell short of the required $1.5 billion. The Special Envoy’s report on “resources-for-results” provided a thorough overview of the needs of affected countries. Country-tailored reports were made available to the Governments of the three most affected countries and provided specific figures of available resources allocated by the major UN entities, as well as funds disbursed.

To contain the Ebola virus disease outbreak, the response needed to be further tailored to the location and spread pattern of the disease. The initial emphasis on containing the spread by finding and isolating infected individuals was now shifting to eliminating transmission wherever it appeared. The response also needed to shift from a country-level approach to a district-level approach. Governments, partners and the UN system were focusing on tailored responses in the 33 districts of Guinea, 15 districts in Liberia and 14 districts in Sierra Leone. The district-by-district approach would be complemented by a rapid response capacity that could be deployed in cases of sudden flare-ups that were beyond the district-level capacity.

To address the impact on essential services, the Mission and resident coordinators of the affected countries were working to ensure a response guided by national priorities. A revision of the overview of needs and requirements for the Ebola response would be published in January 2015. To strengthen the operational link between the Mission and United Nations agencies, funds and programmes involved in the res-